## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/13/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445160	B. WING		08.	/10/2020	
	PROVIDER OR SUPPLIE		200	REET ADDRESS, CITY, STATE, ZIP CC D MAYFIELD DRIVE JYRNA, TN 37167			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE AI DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE	
F 000	was conducted by August 10,2020 a facility was found CFR §483.80 infe has implemented Disease Control a	used Infection Control Survey the the State Agency on t Diversicare of Smyrna. The to be in compliance with 42 ction control regulations and the CMS and Centers for ind Prevention (CDC) actices to prepare for	F 000				
BODATORY	DIDECTORIS OF BROW	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 MAYFIELD DRIVE				
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  200 MAYFIELD DRIVE	445160			
DIVERSICARE OF SMYRNA SMYRNA, TN 37167				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPACT TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX (EA			
A COVID-19 Focused Emergency Preparedness Survey was conducted by the State Agency on August 10, 2020 at Diversicare of Smyrna. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6).	A COV Survey August facility v CFR §4			

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

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Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING:		(X3) DATE SURVEY COMPLETED	
	TN7503	B. WING		08/10/2020	
NAME OF PROVIDER OR SUPPLIER  DIVERSICARE OF SMYRNA	STATE, ZIP CODE				
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
was conducted by th 10, 2020. The facility compliance under Cl for Nursing Homes, i and has implemente Control and Preventi	ed Infection Control Survey the State Agency on August by was found to be in hapter 1200-8-6, Standards infection control regulations d the Centers for Disease ion (CDC) recommended for COVID-19. Total census	N 000			

Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE